DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/17/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155400		(X2) MULT A. BUILDII B. WING		OO	(X3) DATE SURVEY COMPLETED 04/07/2011		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 4600 EAST JACKSON ST MUNCIE, IN47303				
(X4) ID PREFIX TAG F0000	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PRI	D EFIX AG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	Complaint IN000 Complaint IN000 federal/state defit allegations cited Survey dates: Approvide allegations cited Survey dates: Approvider number: Provider number: AIM number: Surveyor: Jeri Curcensus bed type: SNF/NF: 88 Total: 88 Census payor type Medicare: Medicaid: Other: Total: Sample: 3 These deficience findings cited in 16.2.	088811- Substantiated, ciencies related to the at F225 and F226. oril 6, 7, 2011 000269 :155400 100267720 artis, RN	F000	0	Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth the statement of deficiencies. This plan of correction is prepared and submitted because of requirement under state and federal law. Please find enclot the plan of correction for the survey ending April 7, 2011. It to the low scope and severity the survey findings, please a find enclosed sufficient documentation providing evidence of compliance with plan of correction. The documentation serves to corthe facility's allegation of compliance. Thus, the facility respectfully requests the graof paper compliance. Should additional information be necessary to confirm said compliance, feel free to contime. Respectfully, John H. Everhart RN, HFA, MBAAdministrator	he non osed Due y of olso the offirm nting	
LABORATOR	Y DIRECTOR'S OR PROV	TDER/SUPPLIER REPRESENTATIVE'S SIG	GNATURE		TITLE		(X6) DATE

(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

62IL11

Facility ID:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION 00	(X3) DATE SURVEY COMPLETED		
		155400	B. WING		04/07/2011		
NAME OF PROV	VIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 4600 EAST JACKSON ST MUNCIE, IN47303				
(X4) ID PREFIX	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)				
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE		
F0225 SS=D The had or had numining of had errest the autorial the with (in ag) The allerest the autorial the with the series of the with (in ag) The allerest the autorial the with the series of	we been found g mistreating residence had a finding inse aide registry istreatment of residence in their property; and is of actions by an analyse, which we revice as a nurse is State nurse aidenthorities. The facility must end an intervention of the state in the	ot employ individuals who uilty of abusing, neglecting, dents by a court of law; or entered into the State concerning abuse, neglect, sidents or misappropriation and report any knowledge it court of law against an would indicate unfitness for aide or other facility staff to de registry or licensing ansure that all alleged mistreatment, neglect, or juries of unknown source on of resident property are easy to the administrator of other officials in accordance ugh established procedures atte survey and certification are thoroughly investigated, further potential abuse while in progress. Investigations must be ministrator or his designated to other officials in tate law (including to the ertification agency) within 5 to incident, and if the alleged appropriate corrective	F0225	A thorough investigation of incident for Resident C has been seen as a second control of the control of th			
in	nterview, t	he facility failed		completed and reported to			

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			LDING	00	COMPLET 04/07/201	ED	
		155400	B. WIN			04/07/201	1
NAME OF	PROVIDER OR SUPPLIEI	3			DDRESS, CITY, STATE, ZIP CODE		
LIBERTY	/ VILLAGE			1	AST JACKSON ST E, IN47303		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES SICY MUST BE PERCEDED BY FULL LISC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE .	(X5) COMPLETION DATE
	to assure 2	employees, a			ISDH.LPN #1 and CNA #1 h been re-educated on immed	· ·	
	licensed nu	ırse and a			reporting alleged abuse to administration at the time of		
	certified nu	ursing assistant,			occurrence. The employme CNA #2 has been terminate	nt of	
	immediate	ly reported to the			subsequent to the investigat	ion of	
	administra	tor an allegation			the incidents completed and reported to ISDH.2. All other	er	
	of verbal a	buse by a staff			residents have the potential affected. The facility's report	of	
	member to	ward 1 (Resident			concerns have been reviewed and if alleged abuse was for		
	C) of 2 res	idents among the			complete and thorough investigation has been comp	oleted	
	sample of 3	3 reviewed for			and submitted to ISDH. Ale oriented residents and staff	rt and	
	abuse.				interviewed to determine if a other potential abuse allega	iny	
	The facility	y also failed to			were in need of investigation	ո.3.	
	assure a th	orough			The facility's policy and proc on abuse has been reviewed	d and	
	investigati	on of the			no changes are indicated at time (See Attachment A).		
	allegation	with an initial			staff have been re-educated abuse and abuse reporting.		
	report, and	d a final report, to			Administrator has also been educated on abuse investigation		
	the state su	irvey agency and			and reporting.An Abuse Response Form has been		
	other offici	ials within 5			implemented to ensure repo of alleged abuse to administ		
	working da	ays in accordance			is completed immediately ar		
	with state 1	aw. The facility			alleged abuse is thoroughly investigated and reported to	I .	
	failed to pr	event further			ISDH. (See Attachment B). The Administrator/designee	will	
	potential a	buse while the			question 5 staff members or scheduled work days as follo	I .	
	investigation was in			daily for two weeks, weekly two weeks, monthly for two	for		
					months then quarterly there	after	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155400		(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 04/07/2011			
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	progress, Findings in During a 4/ interview, Assistant (continuated sinuitated (Resident Continuated sinuitated (Resident Continuated sinuitated (Resident Continuated sinuitated (Resident Continuated sinuitated sinuita	clude: /6/11, 2:15 P.M., Certified Nursing CNA#1) he had reported another (CNA #2) buse a resident C). dicated she had CNA #2 y attempt to sident C) by eack the curse ch (Resident C)		(See Attachment B). The Administrator/designee will thoroughly investigate and all allegations of abuse on a basis. The Nurse Consulta designee will review all inte and reports of concern wee (See Attachment B) for four weeks, then monthly for two months, then quarterly then to ensure appropriate action been taken. The results of the above reviews will be discurbed during the facility's quarterly meetings and the plans adjuccordingly. 5. The correcting actions will be completed of before April 20, 2011	report a daily nt or rviews kly b eafter n has ne ssed y QA usted ve		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155400		(X2) MU A. BUII B. WIN	LDING	NSTRUCTION 00	(X3) DATE COMPL	ETED		
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	words b	and w to						
	CNA #2. C	NA#1 indicated						
	CNA#2 the	en repeated the						
	words back	to Resident (C),						
	saying she	(Resident C)						
	was a b	and a w						
	CNA#1 in	dicated she had						
	reported th	e incident to a						
	Licensed P	ractical Nurse						
	(LPN #1) a	and to the						
	Director of	Nursing (DoN).						
	CNA#1 in	dicated she had						
	reported th	e allegation 2						
	weeks ago.							
	LPN #1 wa	as interviewed at						
	3:50 P.M.,	4/6/11, and						
	indicated C	CNA #1 had						
	reported an	allegation of						
	witnessing	verbal abuse by						
	CNA #2 to	ward Resident						
	(C). LPN #	#1 indicated						

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	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 4600 EAST JACKSON ST MUNCIE, IN47303					
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	CNA#1 ha	nd reported the						
	incident 3/2	24/11, and had						
	said it had	occurred the						
	previous S	unday $(3/20/11)$,						
	LPN #1 inc	dicated CNA #1						
	had alleged	d CNA #2 had						
	egged Resi	dent (C) on by						
	repeating the	he foul language						
	which (Res	sident C) had						
	said back to	o(Resident C).						
	had been p morning of Documenta indicate a 3 an allegation abuse by C Resident (C	ation did not 3/24/11, report of on of verbal ENA #2 toward C).						
		of Resident (C) yed 4/6/11, at						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155400		(X2) MULTIPL A. BUILDING B. WING	E CO	NSTRUCTION 00	(X3) DATE COMPI 04/07/2	ETED		
	PROVIDER OR SUPPLIE	2	STREET ADDRESS, CITY, STATE, ZIP CODE 4600 EAST JACKSON ST MUNCIE, IN47303					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 3:10 P.M., and indicated a		ID PREFI		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE	
	7/2/09, adr							
	Diagnoses	included, but						
	and dement The care possible 3/10/11 contains abuse by R staff, and easily anger others. The included requiet envir	mited to anxiety tia. lan included ncerns of verbal lesident (C) to (Resident C) was ered toward e interventions emoving to a onment and ly notifying the						
	A joint interview was conducted with the Administrator and the DoN at 4:00 P.M., 4/6/11. The DoN indicated she had not received an allegation							

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155400			LDING	NSTRUCTION 00	(X3) DATE COMPI 04/07/2	ETED	
	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE AST JACKSON ST E, IN47303		
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	of abuse du	ring the past 4					
	months.						
	The DoN in	ndicated on					
	3/25/11, sh	e had received a					
	report of co	oncern from					
	CNA#1 of	an inappropriate					
	conversation	on by CNA #2					
	toward Res	sident (C).					
	The Admin	istrator indicated					
	CNA #2 ha	d allegedly					
	prompted a	gitation from					
	Resident (0	C) by using					
	inappropria	ite language.					
	The DoN in	ndicated she had					
	investigate	d the allegation,					
	which had	occurred					
	3/24/11, in	the assist dining					
	room at the	e evening meal.					
	The DoN is	ndicated a					
	second LPI	N (#2) was					
	present in t	he dining room					
	and had sai	d he did not					

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	witness an	incident. The						
	DoN indica	ated a 3rd LPN						
	(#3) had al	so been in the						
	area and ha	nd not witnessed						
	the inciden	t.						
	On 4/7/11,	at 9:40 A.M.,						
	LPN #3 wa	as interviewed						
	and indicat	ed she was						
	unaware of	fany allegation						
	of verbal a	abuse.						
	LPN #2 wa	as not scheduled						
	on duty 4/6	6, nor 4/7/11.						
	LPN #2 wa	as unavailable by						
	telephone f	for interview.						
	At 10:00 A	1.M., $4/7/11$, the						
	Administra	itor indicated he						
	had review	red the $3/24/11$,						
	report of co	oncern, and the						
	3/25/11, in	vestigation and						

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	PROVIDER OR SUPPLIER		STREET A	ADDRESS, CITY, STATE, ZIP CODE AST JACKSON ST E, IN47303	1	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	could not f	ind mention of a				
	date of occ	urrence of the				
	event other	than 3/24/11.				
	The Admin	istrator also				
	provided a	copy of the				
	3/24/11, re	port of concern				
	completed	by CNA#1,				
	which he in	ndicated was				
	received th	e morning of				
	3/25/11. Th	ne Administrator				
	indicated th	ne report had				
	been slippe	ed under his door				
	the mornin	g following the				
	alleged eve	ent.				
	Documenta	ation on the				
	report of co	oncern indicated				
	CNA#1 ha	d over heard				
	CNA #2 di	recting foul				
	language to	oward (Resident				
	C) in the di	ining room at the				
	evening me	eal time. CNA #1				
	alleged CN	A #2 was				

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				NSTRUCTION 00	COMPL		
		155400	A. BUI B. WIN	LDING NG		04/07/2	011
NAME OF I	PROVIDER OR SUPPLIER		•		DDRESS, CITY, STATE, ZIP CODE AST JACKSON ST		
LIBERTY	VILLAGE			1	E, IN47303		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT TAG DEFICIENCY)		ATE	(X5) COMPLETION DATE
	deliberately	y attempting to					
	agitate (Resident C). CNA						
	#1 docume	nted (Resident					
	C) had star	ted calling CNA					
	#2 bad nan	nes and (CNA					
	#2) had reb	ounded the same					
	names bacl	x to (Resident C).					
	CNA#1 do	ocumented CNA					
	#2 had also	refused to					
	provide a d	rink of water					
	(Resident 0	C) had requested					
	due to the l	oehavior.					
	The Admin	istrator's					
	3/25/11, in	ternal					
	investigation	on of the 3/24/11,					
	report of co	oncern indicated					
	on intervie	w, CNA #1 gave					
	a follow-up	statement of					
	CNA #2 be	eing					
	inappropria	ate with Resident					
	(C), and,						
	"teasing ab	out but not					

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				ONSTRUCTION 00	(X3) DATE S COMPL		
		155400	A. BUII B. WIN			04/07/2	
NAME OF F	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
LIBERTY	VILLAGE				AST JACKSON ST E, IN47303		
(X4) ID		TATEMENT OF DEFICIENCIES	Т	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	· ·	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤE	COMPLETION DATE
	verbally ab	usive."	Ī				
	At 10:50 A	.M., 4/7/11, a					
	conference	phone call was					
	held with the	ne Administrator					
	and LPN #	1.					
	LPN #1 wa	s asked to					
	clarify the	date the					
	allegation of	of verbal abuse					
	by CNA #2	had been made.					
	LPN #1 rep	oorted she had					
	checked wi	th CNA #1 after					
	she (LPN #	(1) had been					
	interviewed	d (by the					
	surveyor) 4	-/6/11. LPN #1					
	indicated C	NA #1 had said					
	the witness	ed verbal abuse					
	had occurre	ed at meal time					
	(5:00 or 5:3	30 P.M), 3/24/11.					
	`	licated CNA #1					
	had reporte	d the allegation					
	•	00 P.M., 3/24/11.					
		,					

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	LPN #1 inc	dicated CNA #1			
	was unsure	how to report			
	the inciden	t. LPN #1			
	indicated s	she had told			
	CNA #1 to	write the			
	incident on	a report of			
	concern an	d give it to the			
	Administrator.				
		ll tag relates to IN00088811.			
	3.1-28(c)				
	3.1-28(d)				
	3.1-28(e)				
F0226 SS=D	written policies and mistreatment, negrand misappropriated Based on reconsinterview, the assure the facing procedures for	facility failed to lity's policies and reporting allegations administrator, and	F0226	A thorough investigation of incident for Resident C has be completed and reported to ISDH.Employee E has completed in abuse prohibition residents rights. All other residents have the potential affected. The facility's report concerns have been reviewed.	oleted and to be of

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUI	X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 04/07/2011	
PROVIDER OR SUPPLIE	II R	B. WIIV	STREET A	ADDRESS, CITY, STATE, ZIP CODE AST JACKSON ST E, IN47303		
residents from investigation (Resident A) (the sample of The facility al (Employee E whose person reviewed for abuse prohibit to beginning a accordance where the sample of the sample of the sample of the sample of The facility al (Employee E whose person reviewed for abuse prohibit to beginning a accordance where the sample of the sampl	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL RESC IDENTIFYING INFORMATION) In abuse during the were followed for 1 of 2 residents among 3 reviewed for abuse. Iso failed to assure 1 of 5 employees, mel files were resident rights and tion, was trained prior employment in ith facility policy. Ide: 4/6/11, 2:15 P.M., tified nursing A#1) indicated she	B. WIN	STREET A	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIMENT OF COMPLETE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIMENT OF THE ADMINISTRATION OF THE APPROPRIMENT OF THE ADMINISTRATION OF COMPLETE OF T	und, a pleted ert and were any ations n.The the viewed bition en The and no is time taff abuse n lation	(X5) COMPLETION DATE
employee (CN a resident ((R CNA#1 indica CNA #2 delib agitate (Resident C) I CNA#1 indica who was cogr	erately attempt to ent C) by repeating e words which			alleged abuse is thoroughly investigated and reported to ISDH. (See Attachment B) Abuse Resident Rights Orientation Form has been implemented to ensure traist completed at hire. (See Attachment C)4. The Administrator/designee will question 5 staff members of scheduled work days as foldaily for two weeks, weekly two weeks, monthly for two months then quarterly there (See Attachment B). The Administrator or designee will all the signer of the staff members of the signer of th	n lows:	

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	then repeated Resident (C), C) was a b CNA #1 indic the incident to Nurse (LPN # of Nursing (D indicated she allegation 2 w LPN #1 was in P.M., 4/6/11, #1 had reported witnessing very #2 toward Resident 3/24/ had occurred to (3/20/11), LPN #1 indicated CNA incident 3/24/ had occurred to (3/20/11), LPN #1 indicated CNA incident (C) of foul language had said back. The reportable provided the reportable provided the resident (C).	ated she had reported a Licensed Practical 1) and to the Director oN). CNA #1 had reported the eeks ago. Interviewed at 3:50 and indicated CNA ed an allegation of abuse by CNA sident (C). LPN #1 A #1 had reported the 11, and had said it the previous Sunday ated CNA #1 had		review employee files for makines on scheduled work do follows: One time weekly ongoing basis (See Attache C)The Administrator/design thoroughly investigate and all allegations of abuse on basis. The Nurse Consultate designee will review all integrated and reports of concern weeks, then monthly for two months, then quarterly therefore to ensure appropriate actic been taken. The results of the above reviews will be discutduring the facility's quarter meetings and the plans and accordingly. The correct actions will be completed to before April 20, 2011	ays as on an ment nee will report a daily ant or erviews ekly r o eafter n has he ussed y QA usted ive	

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M	ULTIPLE CO	INSTRUCTION 00	(X3) DATE S COMPL	
ANDILAN	or correction	155400	A. BUI			04/07/2	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF F	PROVIDER OR SUPPLIER				AST JACKSON ST		
LIBERTY	VILLAGE			MUNCI	E, IN47303		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	*	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION DATE
		t of an allegation of					
		y CNA #2 toward					
	Resident (C).	<i>y</i>					
	resident (e).						
	The record of	Resident (C) was					
	reviewed 4/6/11, at 3:10 P.M., and						
		2/09, admission.					
	Diagnoses included, but were not						
	limited to anxiety and dementia.						
	The care plan included						
	_	erns of verbal abuse					
	by Resident (C	C) to staff, and					
	`	vas easily angered					
		The interventions					
	included remo	ving to a quiet					
		nd immediately					
	notifying the n	iurse.					
	, ,						
	A joint intervie	ew was conducted					
	with the Admi	nistrator and the DoN					
	at 4:00 P.M., 4	1/6/11.					
	The DoN indic	cated she had not					
	received an all	egation of abuse					
	during the past	t 4 months.					
	The DoN indic	cated on 3/25/11, she					
	had received a	report of concern					
	from CNA #1	of an inappropriate					
	conversation b	y CNA #2 toward					
	Resident (C).						

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND FLAN	OF CORRECTION	155400	A. BUII		00	04/07/2011
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIER				AST JACKSON ST	
LIBERTY	VILLAGE			MUNCI	E, IN47303	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
PREFIX TAG	*	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	COMPLETION DATE
		rator indicated CNA		_		
	#2 had alleged	lly prompted agitation				
	from Resident	(C) by using				
	inappropriate language.					
	The DoN indic					
	investigated th					
	had occurred 3	3/24/11, in the assist				
	dining room at	t the evening meal.				
	The DoN indic	cated a second LPN				
	(#2) was prese					
	and had said h	e did not witness an				
	incident. The I	DoN indicated a 3rd				
	LPN (#3) had	also been in the area				
	` /	itnessed the incident.				
	On 4/7/11, at	9:40 A.M., LPN #3				
	was interviewe	ed and indicated she				
	was unaware o	of any allegation of				
	verbal abuse.					
	LPN #2 was no	ot scheduled on duty				
	4/6, nor 4/7/11	. LPN #2 was				
	unavailable by	telephone for				
	interview.					
	At 10:00 A.M.					
	Administrator	indicated he had				
	reviewed the 3	3/24/11, report of				
	concern, and the	he 3/25/11,				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155400		(X2) MULTIPL A. BUILDING B. WING	E CON	NSTRUCTION 00	(X3) DATE S COMPL 04/07/2	ETED	
NAME OF PE	ROVIDER OR SUPPLIER		STRI 460	0 EA	DDRESS, CITY, STATE, ZIP CODE ST JACKSON ST E, IN47303		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	investigation a mention of a d the event other. The Administr copy of the 3/2 concern comple which he indice morning of 3/2 Administrator had been slipp the morning for event. Documentation concern indicated CNA #2 language toward dining room at time. CNA #1 deliberately at (Resident C). (Resident C) h CNA #2 bad in had rebounded back to (Resident C) also refused to	ate of occurrence of than 3/24/11. ator also provided a 24/11, report of leted by CNA #1, rated was received the 25/11. The indicated the report ed under his door ollowing the alleged in on the report of ted CNA #1 had over directing foul rd (Resident C) in the rate the evening meal alleged CNA #2 was tempting to agitate CNA #1 documented ad started calling ames and (CNA #2) If the same names ent C). In the control of th					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155400		(X2) MI A. BUII B. WIN	LDING	NSTRUCTION 00	(X3) DATE COMPL	ETED	
	PROVIDER OR SUPPLIER		D. WIN	STREET A 4600 EA	DDRESS, CITY, STATE, ZIP CODE AST JACKSON ST E, IN47303		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
TAG	internal invest 3/24/11, report on interview, 0 follow-up state being inapprop (C), and, "teasing about abusive." At 10:50 A.M. phone call was Administrator LPN #1 was as date the allegate by CNA #2 has LPN #1 report with CNA #1 and been intersurveyor) 4/6/CNA #1 had severbal abuse he time (5:00 or 5 LPN #1 indicate the allegate of	igation of the tof concern indicated CNA #1 gave a sement of CNA #2 oriate with Resident to the total to the total		TAG			DATE
		ent on a report of					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	INSTRUCTION 00	(X3) DATE SURVEY COMPLETED	
ANDILAN	or connection	155400		LDING		04/07/2011
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIER			1	AST JACKSON ST	
LIBERTY	'VILLAGE			MUNCI	E, IN47303	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	COMPLETION DATE
	concern and gi	ive it to the				
	Administrator.					
	The facility's (undated) policy of				
	complaints and grievances (report					
	of concern) was provided by the					
	Administrator	at 10:00 A.M.,				
	4/7/11. The po	licy indicated the				
	facility would	investigate and				
	respond to complaints made by an					
	individual resident, resident group,					
	1	r, employee, or other,				
	without fear of	_				
	discrimination					
		indicated at the time a				
	~	voiced, a report of				
		be completed and				
		he Administrator.				
	Procedure #2 i					
	_	vould be completed				
	immediately a					
		indicated following				
	_	on, resolution would				
	on an individu	by the Administrator				
		indicated employees				
		ouraged to utilize the				
	_	ern to document odes of resident				
	winiesseu epis	oucs of restuetti				

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M	ULTIPLE CO	INSTRUCTION 00	(X3) DATE SURVEY COMPLETED
ANDILAN	or connection	155400	A. BUI			04/07/2011
			B. WIN	_	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIER				AST JACKSON ST	
LIBERTY	VILLAGE			MUNCI	E, IN47303	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
PREFIX TAG	*	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE COMPLETION DATE
		e investigation was				
		disciplinary action,				
	in-service, or training, would be					
	conducted as warranted.					
	The facility's 1/06, policy, Procedure for Resident Abuse, was					
	provided 4/6/11, by the					
	Administrator.					
	The policy indicated the purpose					
	was to assure appropriate					
		were in place and				
		sident abuse was				
	suspected or ic	dentified.				
	Procedure #2 i	indicated the				
	individual who	o witnessed the				
	incident would	d immediately notify				
		of the unit the				
	_	pied. The charge nurse				
	_	e the resident to				
	determine if pl	hysical injuries had				
	occurred.					
	Procedure #3 i	indicated the charge				
	nurse was resp	onsible to				
	immediately n	otify the				
	Administrator					
	Procedure #4 i	indicated any staff				
		cated in the alleged				
	_	e removed from the				
						ļ.

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY COMPLETED	
ANDILAN	or connection	155400	A. BUI		00	04/07/2011
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIER			1	AST JACKSON ST	
LIBERTY	VILLAGE			MUNCI	E, IN47303	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE COMPLETION DATE
	facility at once	·				
	1	il the investigation				
	was completed.					
	Procedure #9 indicated an					
	investigation would be conducted					
	to assure other resident had not					
	been affected by the incident.					
	Procedure #12					
	Administrator					
	responsible to notify the following					
	agencies as ou	tlined in the,				
	"Unusual Occi	urrences reporting				
	Policy and Pro	ocedure:" Indiana				
	State Departm	ent of Health, Adult				
	Protective Ser	vices, Ombudsman,				
	corporate Regi	ional Manager, and				
	corporate Nurs	se Consultant.				
	_	yee files were				
		11 at 12:10 P.M.				
	Each nursing e					
		of orientation to				
	_	ion and resident				
	rights prior to	the date of hire.				
		,				
		ise keeping employee				
		hired 2/9/11, did not				
		tation of abuse				
	prohibition in-	service prior to hire.				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155400		(X2) MULTIPLE A. BUILDING B. WING	CONSTRUCTION 00	COM	TE SURVEY MPLETED 7/2011	
	PROVIDER OR SUPPLIER		4600	T ADDRESS, CITY, STATE, ZIP EAST JACKSON ST CIE, IN47303	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
	training for Er requested from 12:15 P.M., on Administrator been appointed indicated he had contracted hou provided orient employees. The contracted Supervisor was 12:20 P.M., 4/4 the drug testing check, medical were provided prior to hire. The Housekee indicated the comployees to a buse in-service facility after the At 12:35 P.M. Administrator been made aw	d to the position, ad just been told the asekeeping service station for their d Housekeeping sinterviewed at 7/11, and indicated g, criminal history l, and job orientation by the company ping Supervisor company sent the new the next available ce offered by the neir hire date.				

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

AND PLAN OF CORRECTION AND PLAN OF CORRECTION DENTIFICATION NUMBER: 155400		A. BUILE	DING	00	COMPL 04/07/2	ETED	
	PROVIDER OR SUPPLIER			STREET AI	DDRESS, CITY, STATE, ZIP CODE ST JACKSON ST E, IN47303		
(X4) ID PREFIX TAG	SUMMARY S (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	indicated he has first abuse pro Employee (E) 3/10/11, over a date. Procedure #8 Resident Abus been provided Administrator, employees we in recognizing	ne Administrator and checked and the hibition in-service had attended was a month after the hire of the facility's 1/06, which had 4/6/11, by the indicated all re to receive training and reporting abuse a general orientation ing process).					